NEW JERSEY DEPARTMENT OF HEALTH
PUBLIC HEALTH SERVICES
DIVISION OF FAMILY HEALTH SERVICES

FAITH IN PREVENTION INITIATIVE

REQUEST FOR APPLICATIONS

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FAITH IN PREVENTION

REQUEST FOR APPLICATIONS (RFA)

I. INTRODUCTION

The New Jersey Department of Health (DOH), Division of Family Health Services (FHS), Community Health and Wellness Unit is announcing a competitive request for applications (RFA) to expand the role of Faith-Based organizations (FBOs) in the delivery of health prevention services in three communities (Trenton/Camden/Newark) as well as establishing partnerships and collaborations between the faith-based and health care systems in those cities.

The mission of the Family Health Services (FHS) Community Health and Wellness Unit is to support cross-cutting public health work that will reduce the burden of chronic disease and improve health outcomes through a combination of evidence-based prevention and disease self-management strategies.

Eligible applicants – non-profit organizations/ faith associations, Accountable Care Organizations (ACOs), and/or faith/health alliances – awarded under this RFA (with funding support from the Centers for Disease Control and Prevention), will 1) increase the use of effective, innovative nutrition education interventions in faith-based organizations; 2) encourage daily physical activity, and promote access to healthy food for low-income residents living in the three target cities; and 3) stimulate and build partnership networks between health care systems and faith-based organizations to improve health outcomes among congregants. This open and competitive RFA process will fund up to three projects at an annual maximum award of $300,000 per awardee, per project period, for a period of three years.

The US Department of Health and Human Services (DHHS), Office of the Surgeon General, National Prevention, Health Promotion and Public Health Council, in 2011 released a National Prevention Strategy-America's Plan for Better Health and Wellness (National Prevention Strategy) to provide an opportunity for the nation to become more healthy and fit. The intent of the strategy is to move the nation from a system of sick care to one based on wellness and prevention and encourage partnerships among federal, state, tribal, local and territorial governments; business, industry and other private sector partners; philanthropic organizations; and community and faith-based organizations to improve health through prevention.

This strategy is in line with DHHS's Healthy People 2020 objectives. Specifically, Healthy People 2020 objective ECBP-10, Educational and Community-Based Programs, targets increasing the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations [such as faith based organizations], and State agencies) providing population-based primary prevention services. The *Faith in Prevention* initiative is focused on awarding eligible applicants in the target cities that demonstrate the ability to effectively address this objective.

This competitive RFA is for a budget period of up to 12 months (October 1, 2014 through September 30, 2015). Subsequent budget years (2 and 3) will be dependent upon the

continued availability of funds; timely accurate submission of reports; an approved annual plan; satisfactory progress toward completion of the current year's contract objectives; and a well-defined sustainability plan post the three-year award period. In subsequent years, the agency must submit a noncompetitive health service grant application.

Awards will be made based on the quality of the applicant proposal and pending the availability of funds. Funding decisions will be made to ensure the broadest possible coverage, in terms of both geography and prioritized target populations to be served. Applications should be relevant to both the mission of the Department of Health/Division of Family Health Services/ Community Health and Wellness and to the general objectives set forth in this RFA. Given the emphasis of this program announcement on faith-based programs, their community civic bridging activities and the potential impact on health disparities, applications that respond to this announcement must demonstrate clear collaborations or partnerships, including substantive involvement of faith-based programs, the health care systems and residents within their communities or neighborhoods in their proposed projects.

Prospective applicants need to note that Year One of this RFA is financed solely by 2014 Prevention and Public Health Funds under the Preventive Health and Health Services Block Grant (PHHSBG), Centers for Disease Control and Prevention. As such there will be two reporting requirements and timelines. Grantees will be required, under the Prevention and Public Health Fund (PPHF) (Section 4002P.L. 111-148) to report on use of PPHF on a semi-annual basis. These reports will be posted on a federal website and made available to the public. Under the PHHSBG, a second set of reporting requirements, with different timelines will also be required. Grantees awarded a grant under this RFA will be provided with additional information after an award is made.

The DOH/FHS is committed to targeting limited Preventive Health and Health Services Block Grant resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes adversely affected by chronic diseases. Therefore three cities, Newark (Essex County), Trenton (Mercer County) and Camden City (Camden County) have been chosen to implement this project. The three cities have a significant chronic disease burden, increased rates of preventable hospitalizations as well as a substantial number and variety of denominational congregations and congregational adherents--these include full members, their children and others who regularly attend services.

The Association of Religion Data Archives 2010 report indicates that Essex County ranked second highest in the number of congregations with 608 and a total of 444,696 participating congregants. The population of Essex County was 783,969 in 2010; in 2000 it was 793,633. The total population changed -1.2%. The adherent totals of the religious groups (444,696) included 56.7% of the total population in 2010.

Camden is ranked fifth with a total of 372 congregations and 275,475 participating congregants. The population of Camden County was 513,657 in 2010; in 2000 it was 508,932. The total population changed 0.9%. The adherent totals of the religious groups (275,475) included 53.6% of the total population in 2010.

Mercer County ranks tenth with a total of 276 congregations and 192,783 participating

congregants. The population of Mercer County was 366,513 in 2010; in 2000 it was 350,761. The total population changed 4.5%. The adherent totals of the religious groups (192,783) included 52.6% of the total population in 2010.

II. PROPOSAL REQUIREMENTS

1. Applicants proposals must:
   a. Identify a proposed evidence based (best practice) intervention strategy(ies), using the Faithful Families Eating Smart and Moving More (Faithful Families) framework, see Attachment A, and explain how the intervention strategy(ies) will be implemented; and
   b. Propose a new innovative approach to increase partnerships between the faith community and health systems in the target cities to facilitate transitions from hospital to home, reducing mortality, utilization, and costs associated with readmission. See Attachment B for an example of an innovative initiative for FBOs to address chronic disease.
2. Applicants must explain how the proposed project addresses chronic disease risk factors and will improve health outcomes
3. Applicants must describe how they will cooperate and work with the Department's designated Project Evaluator for this Initiative and submit data as required.
4. Applicants must describe how the proposed project aligns with Healthy People 2020 objective ECBP 10.7, 10.8, and 10.9, to increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services in the areas of chronic disease, nutrition and physical activity, and Healthy New Jersey 2020 objectives related to obesity as listed below:
   a. Prevent an increase in obesity for residents 14-18 years old
   b. Increase physical activity for residents 14-18 years old from 21.3% to 23.4%
   c. Increase daily consumption of fruits and vegetables for residents 14-18 years old from 20.1% to 22.1%
   d. Reduce soda consumption for residents 14-18 years old from 19.9% to 13.9%
   e. Reduce computer time to 2 hours a day maximum for residents 14-18 years old from 28.9% to 26%
   f. Reduce TV time to 2 hours a day maximum for residents 14-18 years old from 32.6% to 29.3%
   g. Prevent an increase in adult obesity
   h. Increase adult physical activity from 53.2% to 58.5%
   i. Increase adult daily consumption of fruits and vegetables from 26.1% to 28.7%
5. Applicants must explain how the proposed project will: increase the number of FBOs in Camden, Newark, and Trenton that establish policies to support implementation of Faithful

Families Eating Smart and Moving More (FFESMM) within congregations in the target cities; increase the number of congregants who have adopted healthy eating and active living practices, through the FFESMM curriculum, to improve health outcomes; creates and strengthens partnerships between FBOs and local health systems for the purpose of establishing discharge planning arrangements between the two groups to enable FBOs to assist congregants in driving down readmissions/unnecessary use of hospital emergency departments; and interacts with other organizations, such as: CBOs, FBOs, local public health departments, schools, federally qualified health centers, or other 501(c)(3) not for profits and local hospitals.

   a. Applicants must include a letter of support from key partnering organizations with the proposal.

III. GENERAL REQUIREMENTS

1. Complete the grant application online at DOH SAGE at https://enterprisegrantapps.state.nj.us/NJSAGE
2. Internet capability and resources, including connection to an IP (internet provider) such as Verizon, Comcast, Clear or other IP.
3. Show evidence of networking and alliance building capabilities required to implement the proposed project initiative with organizations such as but not limited to CBOs, FBOs, schools, businesses, clinics, local government, and others. Provide at least one letter of support outlining the relationship or intended relationship with a community partner.
4. Have the capability of hosting self-management and/or health education sessions within the organization's facilities or to secure suitable facilities with a community partner.
5. Pay for the cost of purchasing specific curriculum, licenses, materials and professional consultants required to implement the project initiative. Costs may be included as part of budget.
6. Attend all meetings related to this Pilot Program; including the mandatory Technical Assistance (TA) meeting for all Applicants interested in applying for this RFA. One or more representatives must attend Technical Assistance meetings (dates to be determined). TA meetings will be facilitated by DOH/FHS.
7. This RFA is financed solely by 2014 Prevention and Public Health Fund dollars under the Preventive Health and Health Services Block Grant (PHHSBG), Centers for Disease Control and Prevention. As such there will be two reporting requirements and timelines. Under the Prevention and Public Health Fund (PPHF) (Section 4002P.L. 111-148) grantees will be required to report on use of PPHF on a semi-annual basis. These reports will be made available to the public. Under the PHHSBG, a second set of reporting requirements, with different timelines will also be required. Grantees awarded a grant under this RFA will be provided with additional information for all due dates, applicable templates and specific data to be reported on after an award is made.

IV. TECHNICAL ASSISTANCE

1. The DOH/FHS will provide technical assistance to grantees through conference calls and/or in-person meetings. The conference calls will address specific implementation challenges and provide grantees an opportunity to showcase progress.
2. Site visits will be conducted by DOH/FHS, as appropriate.
3. When required, all grantees will participate in meetings or webinars and, maintain open channels of communications with the DOH/FHS.

V. FUNDS AVAILABILITY

The Department expects to have available $900 thousand dollars for funding for this Initiative. These funds are available from federal funding award to the DOH/FHS by the Centers for Disease Control and Prevention/Preventive Health and Health Services Block Grant. The award of grants under this announcement is contingent upon the continued receipt of these federal funds by the DOH/FHS.

The Department anticipates making funding awards for the three (3) cities (Camden, Newark, and Trenton) to applicants who can successfully meet the program and project criteria described in this announcement. Population size, chronic disease burden and geographic distribution will be considered in determining award levels at the Department's discretion.

This competitive RFA is for a period of up to 3 years. Year 1 Budget Period will be for one (1) year (October 1, 2014 through September 30, 2015) and is dependent upon the continued availability of funds. In subsequent years (October 1, 2015 – September 30, 2016 and October 1, 2016 – September 30, 2017), the agency must submit a noncompetitive health service grant application. Each year continuing funding is contingent upon the availability of funds; timely accurate submission of reports; an approved annual plan; and satisfactory progress toward completion of the current year's contract objectives. The Department no longer **recognizes indirect costs as an allowable cost** of grants.

Funding under a grant is expressly dependent upon the availability of funds to the Department appropriated by the State Legislature from State or Federal revenue or such other funding sources as may be applicable. The Department shall not be held liable for any breach of this agreement, because of the absence of available funding appropriations. The grant award will further be contingent upon the fiscal and programmatic completeness of your application, as well as the fulfillment of the current grant objectives.

Awards will be made based on the quality of the applicant proposal in meeting the goals and objectives of the RFA and on a sustainability plan post the three year period. Future funding will also depend on the availability of funds. Funding decisions will be made to ensure the broadest possible coverage, in terms of both geography and prioritized target populations to be served.

The Department will not be able to provide cash payment until a fully executed Notice of Grant Award is in place.

VI. ELIGIBILITY

The awarding of grants is on a competitive basis and is contingent upon applications deemed fundable according to the RFA review process by DOH officials and compliance, **per each year of the grant cycle,** with:

1. The DOH Terms and Conditions for Administrative Grants.
2. Applicable Federal cost Principles-Addendum to the Terms and Conditions for Administration Grants.
3. General and Specific Compliance Requirements from the DOH/FHS.

Eligible applicants **must** have a New Jersey not for profit status with a 501(c)(3) tax exempt status. Eligible applicants include all non-profit community based agencies, faith based institutions and/or alliances/ coalitions/collaborative/ACOs, which meet the requirements of this RFA.

All applications that meet the minimum requirements will undergo a review process, as described below.

Any agency or program that has been disbarred or is under suspension by the DOH or other governmental agency is not eligible.

All information submitted with your application is subject to verification during pre-decisional site visits and review by DOH staff.

Verifications may include, but are not limited to, review of client records without identifiers, credentials of staff, progress reports submitted to funders, fiscal policies, procedural policies (including cultural competency policy) and procedures, etc.

VII. PROOF OF ELIGIBILITY

Applicants are required to submit financial documents, **per each year of the grant cycle,** in accordance to the DOH Cost Controlling Initiatives. Submission of unverifiable information in a proposal may result in an agency not receiving any funds. **Failure to provide required documentation will result in disqualification**. Please attach the requested documents in word or PDF to your application through the DOH System for Administering Grants Electronically (SAGE):

1. Valid Internal Revenue Services (IRS) 501(c)(3) tax exempt status.
2. Statement of Total Gross Revenue and/or Annual Report (if applicable). If grant is less than $100,000 and agency doesn't receive any other funds from the state or federal government an audit report is not required. Agency should submit the Statement of Total Gross Revenue in order to determine if an audit report is required.
3. Tax Clearance Certificate is to be submitted—Application for Tax Clearance can be obtained at http://www.state.nj.us/treasury/taxation/busasst.shtml (fee of $75.00 or $200.00).

VIII. APPLICATION AND DELIVERABLES

The Application must be uploaded into SAGE, per each year of the funding cycle, and must include the information below, in the order as presented and identified by Section:

Section 1-Background/Organizational Capacity (20 points)

- Provide a brief description and history of the organization;
- Provide an organizational chart that describes the location of this program within the organizational structure; and
- Describe the experience of the applicant organization in providing services in the proposed city.
- Describe the major linkages with community (public and private) organizations (e.g., other health care programs, human service agencies, health professional education programs, integrated service networks, school systems, housing programs, etc.).

Section 2- Needs Assessment (20 points)

- Identify the proposed target population and service area.
- Identify existing service location in the city to be served.
- Documentation of clients is required including demographics of population to be served including but not limited to age, race, ethnicity, language, insurance status.
- Describe how the proposed program complements existing services in the community.
- Describe the extent to which current referrals are coordinated and integrated with the activities of other community programs serving the same populations(s).
- Identify formal linkages /partnerships/collaborations with at least 10 faith-based organizations and health care systems in your target city.
- Describe both formal (attach letters of agreement) and informal arrangements.
- Include a time specific project plan that demonstrates that the agency/organization will be operational within 30 days of receipt of grant award.

Section 3-Project Plan for Service Delivery (50 points)

- Describe the organization's general approach to meeting community/target population of individuals and families.
- Describe the proposed service model and the services to be provided.
- Describe the proposed staffing and agency readiness of the program. (Include ability to hire, facility space.)
- Describe how the proposed projects are most appropriate and responsive to the identified issues related to this RFA.
- Describe the extent to which project activities are coordinated and integrated with the activities of other federally funded, State and local health services delivery projects and programs serving the same population(s).
- Describe, in cases where the site is already operational, how grant funds will enhance existing services, resources and providers to expand accessibility and availability of health care services to underserved populations.

Section 4-Budget and Justification (10 points)

- The budget should be developed based on the estimated funding needs to accomplish the proposed project, not to exceed $300k annually.
- Health Service Grant Application Schedule A, B, and C must be completed.
- Identify the number of full time equivalents regardless of funding source that will be providing services for the program.
- The budget should be accompanied by a complete and comprehensive budget justification that provides an explanation for each budget line item.
- The budget should be reasonable and appropriate based on the scope of the services to be provided.
- Identify all state and federally funded initiatives in the project area which your agency is funded.

After applications have been scored and ranked by the review committee, DOH/FHS staff will review the budget request. An application must receive a minimum score of 70 points to be eligible for funding. The DOH/FHS may negotiate specific line items that it determines to be inappropriate, excessive or contrary to the DOH/FHS grant policy.

IX. REVIEW PROCEDURES

1. Applications received by the deadline will be screened for compliance with the mandatory requirements by DOH/FHS staff.
2. Applications that are incomplete or do not conform to the grant requirements will be disqualified.
3. Applications that meet the screening requirements will be presented to DOH/FHS RFA review committee.
4. The review committee will assess each application according to the Evaluation Criteria described below.

X. SUBMISSION OF APPLICATIONS

In order to submit a proposal online, via the **System for Administering Grants Electronically (SAGE):** ***If your organization is already registered in SAGE****, you will be able to logon and begin the application process once the application is available (date will be provided at the Bidders' Conference/ Technical Assistance Meeting).*

If you are a first time DOH applicant whose organization has never registered in the DOH SAGE, you **must** contact Anna Battle, Anna.Battle@doh.state.nj.us (609) 292-5616, complete a New Agency form, and submit it to the DOH. The Department will review the documents to ensure applicants have satisfied all the requirements. When approved, the organizations' status will be activated in SAGE. The SAGE Coordinator will grant permission (via email) to the organization to access the application with an activated status.

Instructions for New Agency:

- Complete the form ***Adding Agency Organizations into NJSAGE***

identify your validated Authorized Official, or if none, have the Authorized Official register as a new user. The new user (Authorized Official) will be validated with the organization and assigned to the organization.

- Sign a **hard copy** of the form ***Adding Agency Organizations into NJSAGE*** and submit it via FAX or as an e-mail attachment to Ms. Anna Battle,

FAX (609) 292-9599 or email address: Anna.Battle@doh.state.nj.us.

Note: If you have previously applied in SAGE, please do not reapply. Your organization/agency information is maintained by the SAGE.

XI. APPLICATION REVIEW AND AWARD SCHEDULE

August 11, 2014	Release of RFA
August 15, 2014	Letter of Interest Deadline Monique.Howard@doh.state.nj.us
August 22, 2014	Technical Assistance meeting
August 22, 2014	Application open in SAGE
September 16, 2014	Application due in SAGE (3:00 pm)
September 30, 2014	Application review/determination
October 1, 2014	Notice of Grant Award
October 1, 2014	Project Begins

Potential applicants are **required** to send a **letter of intent** through email expressing their interest in submitting an application in response to this RFA. An email "Notice of Intent to Apply" must be sent via email to the Executive Director no later than 12 noon, **August 15, 2014**. Contact information is provided below:

Monique Howard, EdD
Executive Director
Community Health and Wellness Unit
Division of Family Health Services
Monique.Howard@doh.state.nj.us

Letter of interest must include:

1. Agency Legal Name
2. Agency Address, City, County, Zip

3. Agency Telephone Number
4. Agency Federal ID Tax #
5. Agency Mailing Address for Grant Award Notification (if awarded)
6. Name of person who will be entering the grant application on-line
7. E-mail of person completing grant application
8. Statement of whether the applicant agency is already registered in SAGE

XII. DOH CONTACT INFORMATION

SAGE Coordinator, Ms. Anna Battle, Anna.Battle@doh.state.nj.us 609-292-5616

Grants Management Officer (GMO), Mr. Frank Mattozzi, Frank.Mattozzi@doh.state.nj.us

609-984-1315

Program Management Officer – (Program Information) – Monique Howard, Monique.Howard@doh.state.nj.us, (609) 292-8540

ATTACHMENT A

Faithful Families Eating Smart and Moving More

Faithful Families Eating Smart and Moving More (*FFESMM*) is a practice-tested intervention that focuses on healthy environmental and policy changes within faith communities. It also promotes healthy eating habits and increased physical activity through a series of group nutrition/physical activity education sessions.

FFESMM is a faith community-based program that addresses multiple levels of the socio-ecological (S-E) model. The program focuses on both the individual/interpersonal level (group nutrition/physical activity education series) and the organizational level (policy, practice and environmental changes within faith communities).

Combining best practices that target individual behavior with environmental and policy changes, *Faithful Families Eating Smart and Moving More* (*FFESMM)* educates faith community members about food, physical activity and becoming advocates for healthy policy and environmental changes within their communities. *FFESMM* can be used with any faith tradition. Trained lay leaders from individual faith communities are paired with nutrition/physical activity educators to co-teach lessons and deliver the program. *FFESMM* has worked predominantly with low-income African-American faith communities, designated by percentage of their members who are eligible for Medicaid, eligible for free or reduced school lunches and/or are at 200% of the federal poverty level. The program has also demonstrated success in a limited number of non-African-American faith communities. This focus allows faith communities to link economically disadvantaged community members to education and resources, empowering them to eat healthier, increase their physical activity and become advocates for positive policy and environmental changes within their communities

To obtain additional information, please see the links below:
Web links: *Faithful Families Eating Smart and Moving More*
Primary Website: http://www.faithfulfamiliesesmm.org/
Facebook Page: https://www.facebook.com/FaithfulFamiliesEatingSmartandMovingMore

Related Resources:
www.eatsmartmovemorenc.com
www.myeatsmartmovemore.com
www.ces.ncsu.edu/EFNEP/

Publications:
Hardison-Moody A, Dunn C, Hall D, Jones L, Newkirk J, Thomas C. Faithful Families Eating Smart and Moving More: The Role of Volunteer Lay Leaders in the Implementation of a Faith-based Health Promotion Program. International Journal of Volunteer Administration. 2011 July; 28(2), 18-28. Available from URL: http://www.ijova.org/PastIssues/volume_xxviii_02.htm.

Hardison-Moody A, Dunn C, Hall D, Jones L, Newkirk J, Thomas C. Multi-Level Partnerships Support a Comprehensive Faith-Based Health Promotion Program. *Journal of Extension* [On-line], 49(6) Article 6IAW5. Available at: http://www.joe.org/joe/2011december/iw5.php

ATTACHMENT B

Congregation-Health System Partnership to
Support Transition from Hospital to Community

The Congregational Health Network, a partnership between Methodist Le Bonheur Healthcare and 512 FBOs in Memphis, Tennessee is an evidence-based innovative initiative that supports the transition from hospital to home for congregants. Enrolled congregants are flagged by the health system's electronic medical record whenever admitted to the hospital. A hospital-employed navigator visits the patient to determine his or her needs and then works with a church-based volunteer liaison to arrange postdischarge services and facilitate the transition to the community. The liaisons and clergy members also receive training and other benefits from the health system, thus allowing them to serve as role models and provide education to congregants. The program has reduced mortality, inpatient utilization, and health care costs and charges, while improving satisfaction with hospital care.

The evidence for this initiative primarily consisted of 2006 comparisons of key outcomes among program participants and a group of similar individuals who did not participate, including mortality rates, health care costs and charges, readmission rates, time to readmission, home health and hospice utilization, and patient satisfaction. Additional evidence included pre- and post-implementation comparisons of various measures of inpatient utilization and charges in a subgroup of 50 participants.

The program serves the entire Memphis community; however, 86 percent of early-adopter members were urban, lower-income African Americans.

Project coordinators for the initiative recognized that low-income African Americans disproportionally suffer from cardiovascular disease, diabetes, and other conditions that lead to frequent hospitalizations. Once hospitalized, they often have difficulty navigating the system and arranging for postdischarge services, which frequently leads to readmissions. They also lack education about healthy lifestyles that could prevent the development or exacerbation of chronic disease. The Coordinators recognized that FBOs represent a potentially effective but underused resource in promoting health and facilitating transitions in this population.

Key program elements included the following:

- Covenant between health system and FBOs: Health system and FBO leaders sign a covenant to formalize their partnership. The health system agreed to provide training at no charge and to share aggregate performance data. Clergy agreed to be good health role models for their congregations and to help design and test program initiatives and tools. Congregations were classified according to level of engagement:
    - Level 1 congregations signed a covenant only.
    - Level 2 congregations signed a covenant and trained liaisons.
    - Level 3 congregations signed a covenant, trained liaisons, and participated in data analysis and program development.

    - Level 4 congregations signed a covenant, trained liaisons, participated in data analysis and program development, and shared narratives from members.

- Enrollment of congregants: Once a church signed a covenant, congregants could register for the CHN program. Interested individuals completed a form that complied with the Health Insurance Portability and Accountability Act (HIPAA). Information from the form was loaded into the health system's EMR, which flagged individuals as program participants. As of March 2013, more than 14,000 congregants from the 512 participating FBOs had signed up as members of the program.
- Support during and after hospitalization: Health system navigators and church-based liaisons worked together to ensure that program members had a smooth transition from the hospital back to the home after discharge. To that end, they provided support during and immediately after a hospitalization, as outlined below:
    - Identifying participants at admission: The admission staff identified participating individuals through the notation in the EMR. Staff verbally confirmed participation with the patient and verified that he or she would like the congregation notified about the admission. (HIPAA requirements make this opt-in step necessary at each admission.)
    - Navigator notification: The EMR triggered a consult with the navigator assigned to the patient's congregation. The navigator visited the patient and alerted the FBO's health liaison that the member was in the hospital.
    - Liaison support during stay: The liaison visited the patient in the hospital to offer spiritual and emotional support and asked about needs and concerns. The liaison worked within the FBO's existing resources (e.g., visitation teams, fellowship groups, volunteers) to arrange for friends to visit the patient in the hospital and to take care of issues at home, such as pet care, errands, housework, lawn maintenance, and other needs.
    - Arranging and providing postdischarge services: When the patient was ready for discharge, the liaison and navigator worked together to ensure a smooth transition to the home, including arranging for home health care and other community-based social services that might help, such as Meals on Wheels. Liaisons arranged for congregational support, including visits from fellow church members and clergy, meal preparation, grocery shopping, medication pickup, and transportation to followup medical visits. The services provided varied depending on patient needs. For example, to alleviate the security concerns in low-income, urban neighborhoods, a liaison might wait with a patient for a home health provider to arrive, thus avoiding the need for the patient to open the door to a stranger while in the house alone.

- Free training offered by health system: The health system offered free training for clergy, liaisons, and congregants, including sessions on hospital visitation, caring for a newly discharged or dying patient, mental health first aid, formal community health worker certification, navigating the health care and safety net system, and "Better Brains" (a program on early brain development, brain health, and prevention of dementia). Clergy

could also obtain free clinical education through the health system, while enrolled congregants ccould participate in certain health system–sponsored training programs (e.g., computer skills training) free of charge. The health system's educational program had been accepted for certification by two local universities, enabling participants to obtain college credits upon completion.

- Church-based health education: Trained liaisons educated church members on topics related to healthy lifestyles and disease prevention through educational sessions, posting of information on the church bulletin board or in church newsletters, or arranging for outside experts to come to the church to speak about chronic conditions.
- Additional benefits for clergy and congregations: Clergy received a 60-percent discount on out-of-pocket inpatient care costs at Methodist Le Bonheur. Clergy also worked with human resources staff to identify employment opportunities within the health system for parishioners.
- Participation and feedback from clergy and liaisons: Clergy and liaisons could participate in data analysis and program development, and some also shared stories from members to provide anecdotal support of the program.

A faith-based system with 7 hospitals and roughly 1,000 inpatient beds, Methodist Le Bonheur Healthcare serves the Memphis area, with a market share of roughly 47 percent. The system cares for many low-income African Americans, since African Americans make up over half (54 percent) of the city's population and often live in one of many low-income Memphis neighborhoods. Residents of these poverty-stricken communities often face violence and poor health status, driven by high rates of cardiovascular disease, diabetes, and obesity. Memphis has roughly 2,000 churches, and nearly three-fourths of Methodist Le Bonheur patients belong to one of them. African-American clergy in the city have significant social status and power, and the church often forms the basis for the social infrastructure in the community.

The impetus for this program began in 2002. Deeply concerned about health disparities in the city, the chief executive officer of Methodist South Hospital (Mr. Joseph Webb) and the health system's Director of Faith and Community Partnerships (Dr. Bobby Baker) helped develop the CHN, a group of 12 congregations that provided health education to parishioners and assigned liaisons to assist congregants needing hospital care. On his arrival in 2006, the Senior Vice President of Methodist Le Bonheur (Reverend Dr. Gary Gunderson) suggested formalizing and expanding this concept. He felt that a larger network of churches and more formal relationships between the health system and local congregations could improve health and access to care across the service area.

For more information on this innovative initiative, please visit:
http://www.innovations.ahrq.gov/content.aspx?id=3354.

ATTACHMENT C

Faith in Prevention
Sample Timeline

First 6 months 10/1/14 – 3/30/15	Year 1 10/1/14 – 9/30/15	Year 2 10/1/15 – 9/30/16	Year 3 10/1/16 – 9/30/17
Grantee must identify the dedicated staff that will be responsible for overseeing the Faith in Prevention initiative, including conducting trainings, recruiting FBOs for participation in *Faith in Prevention*, monitoring FBO activities and outcomes, evaluating applications for mini-grants and reporting to the NJDOH regarding activities and fiscal management.	Coordinator continues the process to recruit a minimum of 10 congregations for the first year of *Faith in Prevention* and begins training the first cohort of faith leaders to understand the Faithful Families curriculum and the enhanced strategies to improve health outcomes through partnering between FBOs and local health systems.	Coordinator continues the process to recruit a minimum of 10 new congregations for the second year of *Faith in Prevention* and begins training the second cohort of faith leaders to understand the Faithful Families curriculum and the enhanced strategies to improve health outcomes through partnering between FBOs and local health systems.	Coordinator continues the process to recruit a minimum of 10 new congregations for the third year of *Faith in Prevention* and begins training the third cohort of faith leaders to understand the Faithful Families curriculum and the enhanced strategies to improve health outcomes through partnering between FBOs and local health systems.
The identified coordinator completes training within the Faithful Families framework and learns all of the components of the *Faith in Prevention* initiative, including strategies to create partnerships between FBOs and local health systems.	Coordinator conducts a pre-assessment of congregation needs using the Faithful Families assessment tool so that evidence-based strategies that are implemented align with the FBO's specific needs.	Coordinator conducts a pre-assessment of congregation needs using the Faithful Families assessment tool so that evidence-based strategies that are implemented align with the FBO's specific needs.	Coordinator conducts a pre-assessment of congregation needs using the Faithful Families assessment tool so that evidence-based strategies that are implemented align with the FBO's specific needs.
Coordinator recruits a minimum of 10 congregations for the first year of *Faith in Prevention* and begins training the first cohort of faith leaders to understand the Faithful Families curriculum and the enhanced strategies to improve health outcomes through partnering between FBOs and local health systems.	Faith leaders for the recruited congregations (FBOs) use the training received to train congregants to incorporate healthy lifestyles into their daily living, in accordance with the Faithful Families curriculum.	Faith leaders for the recruited congregations (FBOs) use the training received to train congregants to incorporate healthy lifestyles into their daily living, in accordance with the Faithful Families curriculum.	Faith leaders for the recruited congregations (FBOs) use the training received to train congregants to incorporate healthy lifestyles into their daily living, in accordance with the Faithful Families curriculum.

Coordinator conducts a pre-assessment of congregation needs using the Faithful Families assessment tool so that evidence-based strategies that are implemented align with the FBO's specific needs.	Coordinator prepares a competitive bid announcement for congregations to compete for mini-grants to implement evidence-based projects to reduce obesity and correlating chronic disease among congregation members.	Coordinator prepares a competitive bid announcement for congregations to compete for mini-grants to implement evidence-based projects to reduce obesity and correlating chronic disease among congregation members.	Coordinator prepares a competitive bid announcement for congregations to compete for mini-grants to implement evidence-based projects to reduce obesity and correlating chronic disease among congregation members.
Faith leaders for the recruited congregations (FBOs) use the training received to train congregants to incorporate healthy lifestyles into their daily living, in accordance with the Faithful Families curriculum.	Coordinator assembles a panel of reviewers to assess proposals submitted by congregations seeking mini-grants to implement evidence-based strategies to effect policy, environmental and behavioral change within the FBO.	Coordinator assembles a panel of reviewers to assess proposals submitted by congregations seeking mini-grants to implement evidence-based strategies to effect policy, environmental and behavioral change within the FBO.	Coordinator assembles a panel of reviewers to assess proposals submitted by congregations seeking mini-grants to implement evidence-based strategies to effect policy, environmental and behavioral change within the FBO.
Coordinator prepares a competitive bid announcement for congregations to compete for mini-grants to implement evidence-based projects to reduce obesity and correlating chronic disease among congregation members.	Coordinator awards mini-grants to congregations that have minimally met the Level 1 requirements of having received Faithful Families training and implemented an evidence-based strategy to combat obesity within the congregation.	Coordinator awards mini-grants to congregations that have minimally met the Level 1 requirements of having received Faithful Families training and implemented an evidence-based strategy to combat obesity within the congregation and with a goal of identifying and awarding some Level 2 and 3 congregations.	Coordinator awards mini-grants to congregations that have minimally met the Level 1 requirements of having received Faithful Families training and implemented an evidence-based strategy to combat obesity within the congregation and with a goal of identifying and awarding some Level 2 and 3 congregations.
Coordinator assembles a panel of reviewers to assess proposals submitted by congregations seeking mini-grants to implement evidence-based strategies to effect policy, environmental and behavioral change within the FBO.	Coordinator monitors sub-grantee activities as well as the progress being made by congregations that simply adopted the Faithful Families curriculum (without a mini-grant).	Coordinator monitors sub-grantee activities as well as the progress being made by congregations that simply adopted the Faithful Families curriculum (without a mini-grant).	Coordinator monitors sub-grantee activities as well as the progress being made by congregations that simply adopted the Faithful Families curriculum (without a mini-grant).

Coordinator awards mini-grants to congregations that have minimally met the Level 1 requirements of having received Faithful Families training and implemented an evidence-based strategy to combat obesity within the congregation.	Coordinator works with NJDOH and the evaluator for *Faith in Prevention* to demonstrate effectiveness of strategies utilized within the initiative.	Coordinator works with NJDOH and the evaluator for *Faith in Prevention* to demonstrate effectiveness of strategies utilized within the initiative.	Coordinator works with NJDOH and the evaluator for *Faith in Prevention* to demonstrate effectiveness of strategies utilized within the initiative.
Coordinator monitors sub-grantee activities as well as the progress being made by congregations that simply adopted the Faithful Families curriculum (without a mini-grant).			Coordinator presents Sustainability Plan to DOH/FHS and Faith Leaders involved in the Project
Coordinator works with NJDOH and the evaluator for *Faith in Prevention* to demonstrate effectiveness of strategies utilized within the initiative.			

ATTACHMENT D

Additional Information on the Role of FBOs in Chronic Disease Management

The unique role of faith-based organizations as trusted entities and their facilitation of social and health services have been of increasing interest to policymakers, researchers and practitioners, prompting efforts to expand their participation in state and federally funded programs and health disparities efforts. In November 2008, the National Center on Minority Health and Health Disparities in collaboration with the US Department of Health and Human Services, Center for Faith-Based and Community Initiatives held a one-day workshop on "The Science and Practice of Building Partnerships between Faith-Based and Healthcare Organizations towards Eliminating Health Disparities." The purpose of the workshop was to convene faith-based leaders, scientific and policy researchers to explore the role of faith-based and healthcare organizations in addressing health disparities and to provide recommendations for further research. Workshop participants identified effective strategies and recommendations as follows:

- Analysis of faith-based concepts, theories, policies and interventions, including best practices and effective strategies to guide future programming that has the potential to address and eliminate health disparities;
- Development of a meaningful and trusting relationship with academic institutions, health institutions and health professionals in all collaborations;
- Development of evaluation processes that can determine the feasibility and effectiveness of faith-based and faith-motivated programs;
- Availability and access to technical assistance and resources, capacity-building and trainings for faith-based communities to carry out civic bridging activities that influence social determinants of health.

Over the past seven decades, the Gallup Polls have recorded a range of 40% to 45% for Americans who said they attended church, mosque or synagogue within the last seven days. In many minority groups, the church is viewed as an important institution with strong ties to the neighborhood or community. A study conducted by Chaves, et al (2008) revealed that 61% of African Americans attend religious activities at least once a month, compared to 47% among Caucasians. The growing Hispanic population is continuing to transform the nation's religious landscape with an estimated 68% identifying themselves as Catholics (Pew Hispanic Center and Pew Forum on Religion and Public Life, 2008). Similarly, there is a growing cultural diversity within the Asian American population contributing to an expanding diversity in faith-based and multi-ethnic churches.

Many individuals are more likely to attend a faith service than to visit a physician's office. Many mental health services and counseling are delivered informally by clergy serving faith institutions. Religious institutions and their places of worship (or worship services) function as major channels between their communities and the health system contributing to a growing body of evidence on the important role of faith-based interventions in reducing health disparities (CDC 2009). For example, The National Congregations Study revealed that the large majority of US congregations (57 percent) and their members (75 percent of congregants)

already participate or engage in various bridging activities that address health and social determinants of health. Such programs provide food, clothing, housing to needy and homeless, employment, cash assistance to the elderly and needy, educational assistance including tutoring and youth mentoring, neighborhood development projects and access to health programs. Other social services activities that congregations were most likely to engage in were targeted at preventing domestic violence, alcohol, tobacco and substance abuse (Chaves, et al, 2008).

Faith based programs appear to be successful in reaching marginalized and underserved people because of the perception of trust and security that many find in faith communities (Davis, et al., 1990; Hatch & Derthick, 1992). Faith communities and other religious organizations represent a potentially productive avenue into American racial and ethnic minority communities. They function as social centers and educational facilities, as well as health care resource centers (Kong, 1997; Turner, Sutherland, Harris, Barber, 1995; Wiist & Flack, 1990). Indeed, public health and faith communities have a common history of community service and social change around health. Social changes, such as sanitation, disease management, immunizations, and adequate housing, which these groups initiated and sustained, have done much to increase life expectancy and improve quality of life (Gunderson, 1999).

Linking Faith-based organizations (FBOs) with the health care systems is a natural choice. Faith-based organizations have a legacy of providing safety net services in many communities, but have not traditionally been viewed or enlisted as partners to improve community health, while health care systems/institutions have traditionally provided health care to meet the health gaps in communities but have not partnered with faith-based organizations. Historically, faith-based organizations have served as an important gateway to services and care-giving for those living in poverty and in social exclusion. They have taken strong leadership roles in communities and provided job training, housing, economic development, educational support, meals and spiritual support to those in need. Just as health centers have addressed the gaps in health care, faith based organizations have filled the gaps in the delivery of supportive services commensurate with the World Health Organization's broad definition of health including physical, mental, spiritual and social wellbeing (WHO, 1948). Faith-based organizations can bring needed resources, expertise and a shared legacy of caring for these most vulnerable members of society to assist in achieving the goals of the Faith in Prevention Initiative.

It is well recognized that for community health prevention and wellness programs to be successful, they must utilize multiple strategies for interventions. Health educators rely on collaboration because addressing community needs is most effective with active participation and input from the community (Minkler & Wallerstein, 1997). Research indicates that involving community members in the identification of needs, the recognition of assets, and the development of solutions leads to increased community capacity, empowerment, and critical awareness of the community members (Steuart, 1993; Wiist & Flack, 1990). The ultimate goal of all health promotion projects should be to organize communities in an effort to reduce social/physical disease risk factors and increase the quality of life for residents.

FBOs participating in health promotion initiatives have been successful in addressing a number of health-related risk factors and behaviors such as smoking cessation, obesity

prevention/reduction, and sexual/reproductive health (CDC: Healthy Communities Program, 2011; Minkler, Wallerstein & Duran, 2003; Bopp & Fallon, 2008; Kahn, Ramsey & Brownson, 2002; DeHaven, Hunter & Wilder, 2004). Within each of these efforts, spirituality and faith are viewed as a resource to help establish a sense of personal responsibility and respect for one's own life. Obesity prevention interventions that encourage physical activity and/or promote healthy eating have resulted in decreasing physical inactivity and establishing healthy eating behaviors amongst congregation members. The dissemination and execution of culturally and spiritually appropriate materials and activities coupled with pastor/church leader support have resulted in better health outcomes (Bopp & Fallon, 2008). FBOs have facilitated in achieving programmatic successes in health interventions and have also collaborated to change the built environment and assist in the coordination of programs with non-faith based community entities (CDC, 2011).

Throughout the faith-based health promotion literature, key faith leaders are often emphasized as important partners leading to successful program adoption and implementation. These individuals are invaluable to the process of building trusting relationships with congregation members, being a role model for health behaviors and advocating for resources and interest (Baruth, Wilcox & Laken, 2008; Bopp, Wilcox, Laken et al., 2007). Faith leaders hold considerable influence over types of activities offered within their institution, including social, political and philanthropic programs, to health-related topics (Campbell, Hudson, Resnicov, et al., 2007).

Another benefit of partnering with FBOs is the legacy of voluntarism that FBOs bring to any activity. Many underserved areas do not have enough providers and resources to ensure 100% access to health care and wellness programs. Faith-based organizations can help expand the base of services in a given community in a number of ways. First, they frequently have well established volunteer networks that bring both person power and infrastructure to the task of improving individual and community health. These volunteers may include retired health care and social service providers who can expand the pool of providers with little additional cost. These volunteer networks also often serve as extended social support to members of the community. Partnering with support networks can help extend limited health resources by increasing capacity to provide time-consuming and resource intense services needed to successfully manage chronic health conditions. For example, such partnerships can support ongoing and aftercare services for patients with behavioral health problems, adhere to a medical regimen and provide support with diet and weight management for patients with diabetes.

The demographic makeup of New Jersey is constantly changing as a result of immigration and population increases among racially, ethnically, culturally and linguistically diverse groups. New Jersey is one of the most racially and ethnically diverse states in the country. According to

the 2013 New Jersey Population Estimates, 73.8% of the population was white, 14.7% was black, 9.0% was Asian, 0.6% was American Indian and Alaska Native, and 1.9% reported two or more races. In terms of ethnicity, 18.5% of the population was Hispanic. The growing diversity of New Jersey's population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

This diversity creates an impetus for health care organizations to become culturally competent in order to address the wide range of health beliefs, practices and access issues. Sometimes the availability of services is less of an issue than their acceptability to segments of the community. In some communities, culturally diverse groups have been disengaged from or distrustful of health care organizations. When there is such a history, issues of cultural competence and trust must be addressed.

Faith-based organizations can bring important expertise and resources to partnerships with health care organizations. In fact, those that serve particular racial, ethnic and cultural communities can take the role of cultural brokers, helping health care organizations learn about and make connections within these diverse communities. In this way, when health care organizations partner with a faith-based organization it can lead to greater trust among their members and more culturally competent services being provided.

Many of the disparities in health care outcomes relate to the patients' self management of their diseases. In diseases such as diabetes, heart disease and hypertension, for example, changes in diet, exercise, and life style contribute to improved outcomes. Yet these types of behavioral changes are difficult to achieve and require effective health approaches and ongoing support to be sustained. Simply providing patients with "the facts" has not proven to be an effective approach especially when such approaches do not take into account how culture affects health beliefs and practices. Many cultural groups rely on natural networks of support within their communities as a valued source of information for health related issues.

Partnerships between faith-based and health care organizations can provide resources to create the kinds of programs, services and support networks that will improve patient disease prevention and self-management and thus help to prevent future hospitalizations. This is of great importance given that in New Jersey, the rates of potentially preventable hospitalizations are higher for vulnerable populations with limited access to care. In a monograph published by the DOH in 2013 entitled, Prevention Quality Indicators, the authors summarized that "potentially preventable hospitalizations (inpatient stays that might be avoided with the delivery of high quality outpatient treatment and disease management) serve as useful indicators of possible unmet community health needs. By measuring the frequency of such hospitalizations among patient subpopulations, policymakers and providers can identify those communities most in need of improvements in outpatient care as well as the conditions for which care is most needed. R ates of potentially preventable hospitalizations are higher for vulnerable populations with limited access to care. Targeting issues in access to primary care may serve to narrow disparities in health outcomes and improve the quality of care while reducing costs."

For example, national data shows that racial/ethnic populations face a greater risk of getting and dying from chronic illness. African-American adults face twice the risk of being diagnosed with and dying from diabetes than do white individuals. They also face greater risks related to heart disease. Overall, African Americans are 1.5 times more likely to have high blood pressure (a risk factor for the disease) than the average white person, while African-American men are 30 percent more likely to die from heart disease than white men (US Dept Health & Human Services, 2011). African Americans also face greater risk of obesity; women in particular are

affected, with obesity rates of nearly 40 percent (CDC, Office of Minority Health & Health Disparities, 2009).

Care disparities lead to higher rates of hospitalization and rehospitalization. For example, African Americans with diabetes are almost twice (1.7 times) as likely as diabetic whites to be hospitalized, while African-American Medicare beneficiaries with heart disease are hospitalized more frequently than white and Hispanic beneficiaries (with hospitalization rates of 85.3, 74.4, and 73.6 per 1,000 beneficiaries, respectively). Care transitions from hospital to home can be difficult for low-income populations, leading to higher rates of readmission; for example, low-income, ethnic minorities with diabetes are more likely to experience unscheduled readmissions. Low-income Americans and racial/ethnic minorities have limited access to wellness services and education about healthy lifestyles. They also tend to live in environments that support and even promote unhealthy lifestyles (Gettleman & Winkleby (2000).

New Jersey data show a substantial variation in preventable hospital admissions by county and by race. For example, according to the Prevention Quality Indicators report, in 2011, there were 61.4 per 100,000 adults' admissions for diabetes with short term complications. However, for the counties of Essex (100.6) and Camden (95.7), the hospital admission rates were statistically significantly higher than the statewide average. Similarly, rates for hypertension ranged from 17.9 per 100,000 in Hunterdon County to 107.3 in Essex and 121.3 per 100,000 in Camden County. Among racial/ethnic groups, African Americans had the highest rate per 100,000 population of preventable hospitalizations as compared to whites for diabetes (167.1/47.3), hypertension (191.4/52.3) and chronic obstructive pulmonary disease (880.2/528.2).

FBOs are often the most respected and socially powerful organization in low-income African-American neighborhoods. Clergy and other faith-based representatives can promote better health by serving as role models, creating and encouraging use of community-based activities and programs, helping individuals adopt healthier lifestyles, and serving as a link between congregants and the health system (Plesia, Groblewski & Chavis (2008). However, many churches in minority communities do not proactively play these roles, nor do they work closely with local health systems to promote improved community health.

DOH/FHS is interested in promoting innovative interventions that engage FBOs, public health and healthcare providers in promising and successful practices in addressing chronic diseases; enhancing healthful eating and increasing physical activity; and, addressing social and behavioral determinants of health among low-income populations. Faith-based and effective compassionate programs linked with the health care systems in their respective communities have the potential to inform and impact practice and policy, and lead to the reduction of health disparities as well as a reduction in chronic diseases and re-hospitalizations among low-income populations. The focus on the linkages between health care systems and faith-based programs through this mechanism is to 1) support and sustain innovative faith-based programs that address the need for wellness programs; 2) implement targeted evidenced-based interventions and 3) track the efficacy of faith-motivated efforts that result from partnerships and collaborations between the faith-based and health care systems.

Poor diet and physical inactivity are considered leading modifiable risk factors associated with death (McGinnis & Foege, 1993; Mokdad, Marks, Stroup & Geberding, 2004) and these factors

are related with obesity as well as, many other chronic diseases such prediabetes, diabetes, hypertension, heart disease, and stroke. Implementing evidence-based policy and environmental change in order to improve nutrition and physical activity across the lifespan is critical to reducing the chronic disease burden in New Jersey. In order to maximize impact and efficiency, these interventions must be implemented strategically using existing infrastructure in order to reach populations that are most in need including African American residents, Hispanic residents, and those residents with lower education and income levels. Obesity prevalence estimates among New Jersey adults by race/ethnicity are highest for black adults (36.1%) followed by Hispanic adults (26.3%), and then white adults (24.1%). Obesity prevalence estimates among New Jersey adults by household income level are highest for adult residents with a household income level of less than $15,000 (30.1%) and are lowest for adult residents with a household income level of $50,000 or more (23.5%). Obesity prevalence estimates for New Jersey adults by education level are highest for individuals with less than a high school degree (31.7%) and are lowest for college graduates (18.3%) (CDC, NJ Behavioral Risk Factor Survey, 2012).

Camden

Census data indicates that 48.1% of the population in Camden is black and that 47.0% of the city population is Hispanic as compared to 13.7% (black) and 17.7% (Hispanic) for New Jersey overall. An estimated 38.6% of the city population is living below poverty level as compared to 9.9% for New Jersey. In addition, only 64.2% of city residents 25 years and older have received a high school degree and this compares with 87.9% for all New Jersey residents 25 years and older (USCB, 2014). Prevalence estimates for chronic disease are not available for residents of Camden city, but even county level data for 2012 suggest that 30.9% of adults in Camden County are obese as compared to 24.6% for all adults in New Jersey (CDC, NJBRFS, 2012). Furthermore, the 2010 diabetes death rate for Camden city residents was 34.9 diabetes deaths per 100,000 population while the rate was only 23.7 for all New Jersey residents during the same year (NJ Center for Health Statistics, 2014).

Trenton

Census data indicates that 52.0% of the population in Trenton is black and that 33.7% of the city population is Hispanic as compared to 13.7% (black) and 17.7% (Hispanic) for New Jersey overall. An estimated 26.6% of the city population is living below poverty level as compared to 9.9% for New Jersey overall. In addition, only 70.5% of city residents 25 years and older have received a high school degree and this compares with 87.9% for all New Jersey residents 25 years and older (USCB, 2014). Furthermore, the 2010 diabetes death rate for Trenton residents was 38.8 diabetes deaths per 100,000 population while this rate was only 23.7 for all New Jersey residents during the same year. Similarly, the 2010 death rate for heart disease was 228.3 heart disease deaths per 100,000 population as compared to the statewide rate of 211.8 per 100,000 (NJ Center for Health Statistic, 2014).

Newark

Census data indicates that 52.4% of the population in Newark is black and that 33.8% of the city population is Hispanic as compared to 13.7% (black) and 17.7% (Hispanic) for New Jersey

overall. An estimated 28.0% of the city population is living below poverty level (versus 9.9% for New Jersey) and only 70.1% of city residents 25 years and older have a high school degree (versus 87.9% for New Jersey) (USCB, 2014). Prevalence estimates for Newark suggest that about 33.5% of Newark adults are obese as compared to 24.6% statewide. Health survey data also shows that an estimated 37.5% of adults in Newark did not participate in any leisure time physical activity in the prior month, which compares to a much lower 26.0% for New Jersey adults overall. Furthermore, about 12.9% of adults in Newark have diabetes as compared to the statewide estimate of 9.1%. (NJBRFS, 2011-2013). Finally, the 2010 diabetes death rate for Newark residents was 29.2 per 100,000 population while this rate was only 23.7 per 100,000 for all New Jersey residents during the same year (NJCHS, 2014).